Report to the Legislature

Disease Management Pilot Project

Chapter 7, Laws of 2001 E2, Section 209 (6)

January 1, 2002

Department of Social & Health Services
Medical Assistance Administration
Division of Program Support
PO Box 45530
Olympia, WA 98504-5530
(360) 725-1629
Fax: (360) 753-7315

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DISEASE MANAGEMENT PILOT PROJECT
REPORT TO THE LEGISLATURE

January 1, 2002

EXECUTIVE SUMMARY

The Department of Social and Health Services received the directive to "design, implement, and evaluate pilot projects to assist individuals with at least three different diseases to improve their health" in the 2001-03 Operating Budget, Chapter 7, Laws of 2001 E2, Section 209 (6). This report describes the background research and development of the disease management program, including specific steps taken to establish contracts for this service by the end of the year.

Two apparently successful bidders have been identified.

- Renaissance will serve clients with end stage renal disease and is in negotiation to include clients with chronic kidney disease.
- McKesson will serve clients with asthma, and is in negotiation to include clients with diabetes and congestive heart failure.

These companies bring unique approaches to our population, which include active outreach and client education, as well as support for providers who serve our clients.

MAA has designed an evaluation approach that will capture the impact of the disease management pilot project on quality of care, access to services and treatment, and cost. The interim evaluation, projected to be complete one year after the implementation begins, will include measures of client satisfaction, enrollment and participation in the program. The final evaluation will report on costs and utilization as well as quality of care and client health status. The final evaluation relies on complete claims submission, and will be available in 2004.
If you would like more information about this project, including a complete copy of the Request for Proposals, please contact Alice Lind at 360-725-1629 or lindar@dshs.wa.gov.

This document is available in alternative formats to accommodate persons with disabilities. Copies of this document can be obtained in alternative formats by calling (360) 725-1712 or lindar@dshs.wa.gov.

I. INTRODUCTION

A. LEGISLATIVE DIRECTIVE

The Department of Social and Health Services received the following directive in the 2001-03 Omnibus Operating Budget:

> "The Medical Assistance program will research and implement at least three pilot projects to assist individuals with targeted diseases to improve their health. The projects will involve two key components:
>
> 1. identifying persons who are likely to become more seriously ill due to a combination of medical, social, and functional problems; and
> 2. working with them and their primary care provider to improve adherence to state-of -the-art treatment regimens.
>
> Based on successful models in other states, initial diseases to be targeted are likely to include diabetes, asthma, heart failure, renal disease, or cancer. Expenditures on program design and fees for disease case management providers are expected to be offset by 5-10% reductions in the medical costs which program participants would otherwise incur, resulting in a net savings."

In response to this directive, the Medical Assistance Administration took the following steps:

- Conducted research on successful models in other states;
- Convened a panel of experts in the fields of medical care and economics;
- Conducted data analysis on fee-for-service expenditures by disease category;
- Released a Request for Information (RFI) to identify models of disease management;
- Released a Request for Proposals (RFP) to secure contracts with entities able to perform disease management services for the Medical Assistance population;
- Developed an evaluation model for measuring success of the program.

These activities, leading up to contracts with successful bidders, are described in detail in this report.

B. BACKGROUND

The Department of Social and Health Services (DSHS) is the largest agency in Washington state, serving approximately one million Washington state residents each month. In addition to health care services, DSHS services include cash assistance, food stamps and child care assistance, mental health services, treatment for alcohol and substance abuse, vocational rehabilitation, services to the developmentally disabled, long term care and case management.

MAA administers the medical portion of Washington State's Medicaid program, which covers approximately 804,000 residents. Of these, 112,000 are blind and disabled, and 62,000 are elderly. The aged, blind and disabled population represents approximately 22% of the MAA caseload, but utilizes a disproportionate number of health services, consuming 51% of General Fund – State MAA expenditures and 38% of the State's MAA expenditures.

Costs for this population represent the most rapidly increasing area of growth in the MAA budget. Expenditures have increased from $470 million in FY 1996 to about $1 billion in FY 2001. The State has seen total MAA spending rise from $1.6 billion in 1996 to an estimated $2.6 billion in FY 2001.

Many MAA programs provide services to clients on a fee for service (FFS) basis, including clients in the Categorically Needy, Medically Needy and General Assistance – Unemployable and Medically Indigent eligibility categories. One FFS population of concern includes recipients of Supplemental Security Income (SSI). Adult SSI clients have disabilities severe enough to prevent employment for at least one year. SSI clients who are children have functional limitations that significantly affect daily activities.

Most SSI clients have more than one chronic condition that impairs their health and many also have a cognitive disorder such as persistent mental illness or developmental disability. Many SSI clients have complicated needs that require ongoing support from social services to make community living possible. These clients lack the ability to participate fully in their treatment or health care, and require services from many divisions within the department to function successfully. Often multiple case managers are involved in their care.

The FFS program in MAA provides clients with access to health care services, as well as dental care and transportation services. Mental health services are provided separately through a managed care system administered by the Mental Health Division of DSHS. All Medicaid services are delivered by health care providers who are licensed or certified as appropriate, and who have a contract with the department to serve Medicaid clients.

Services provided by other DSHS Divisions

Other state entities, including the Aging and Adult Services Administration and the Mental Health Division's managed care system, may provide focused case management services to selected clients with respect to long-term care, residential or mental health issues. Historically, these case managers have not had a systematic way to communicate with medical providers or each other. One response to this problem is a DSHS initiative called "No Wrong Door." "No Wrong Door" will provide coordinated care for clients receiving multiple services from the department. Multidisciplinary teams will provide services to shared clients in target populations, including clients with multiple disabilities.

Clients may currently be receiving services through any or all of the following DSHS divisions:

> The Mental Health Division (MHD) operates three state psychiatric hospitals; the majority of patients served in this capacity have been judicially committed to state care. Community mental health services are provided by contractual arrangements with individual or multi-county sponsored organizations called Regional Support Networks (RSNs); these RSNs contract with community providers for services that are prioritized for the chronically ill and seriously disturbed individuals. RSNs provide oversight of

care quality in their region and are responsible for hospital admissions, discharge planning and follow-up care.

About 51,000 individuals per month receive state supported outpatient community mental health service. Inpatient care is provided to about 1,600 patients per month in state psychiatric hospitals and approximately 350 patients per month in community-based facilities. Crisis services are available to all state residents through the mental health system, while community support services are provided to individuals based on need. The types of services that are available include case management, medication management, therapy, residential services, supported living, vocational services and community inpatient services.

The Division of Developmental Disabilities (DDD) serves about 33,000 clients. Of these about 1,100 live in five state-operated institutions. Approximately 22,000 of those clients living in the community receive DDD services that may include respite care, family support, birth to three services, employment day programs, residential supports, up to and including twenty-four hour residential services in small (less than 5 person) houses or apartments. DDD also provides case management to assess the needs of clients and families and link those in need to available services.

The Aging and Adult Services Administration (AASA) provides a full array of Medicaid long-term care services for vulnerable adults and seniors with chronic illness and functional disabilities. The average monthly caseload is 45,000. One third of the clients are under age 65. 24,000 clients are served in their own homes. 8,000 clients are cared for in community-residential settings, such as adult family homes and assisted living facilities. 13,000 persons are served in skilled nursing facilities. All Medicaid long-term care clients receive a comprehensive needs assessment and on-going case management. Community-residential clients are managed by AASA staff. Case management for home care clients has been delegated to local Area Agencies on Aging.

Tables in the Attachment provide data about the medical expenses for clients served by these divisions and administrations.

C. DISEASE MANAGEMENT PROJECT OBJECTIVES

Given the challenges of managing clients who may use multiple administrations' services, and are more likely to be disabled than the commercial population traditionally served by disease management contractors, MAA developed the following objectives:

1. Improve adherence to national, evidence-based guidelines whenever possible, to improve clients' health status;
2. Establish a medical home for FFS clients, to increase access to preventive care and improve continuity of care;
3. Reduce overall medical expenditures by at least five percent for the target population;
4. Improve coordination of care with other DSHS divisions that serve these FFS clients as well;

5. Increase client education, self-management skills, and satisfaction; and
6. Increase provider satisfaction with the Medicaid program and with the disease management project.

Over the few months following passage of the Operating Budget, MAA staff undertook several activities to determine how best to meet these objectives, including researching other state and commercial models, reviewing available literature, and analyzing MAA's utilization data with a panel of experts in medical economics.

II. MODELS FOR DISEASE MANAGEMENT (DM)

A. Other States' Experience

In August 2001, the National Governors' Association Center for Best Practices sponsored a conference for state staff to learn about models of DM that have been developed by state agencies. There are two basic models, locally or internally developed approaches, and DM programs purchased from commercial vendors.

Locally developed Disease Management

Several states have developed disease management programs for Medicaid clients. Programs in Hawaii and New York were developed by their Department of Health staff, and have a focus on public education campaigns to improve knowledge of disease prevention and treatment. Virginia developed its program in cooperation with providers around the state, and a major component involved teaching providers how to communicate more effectively with patients to improve compliance. North Carolina, in its ACCESS II and III projects, supports locally developed projects which emphasize individual case management of clients with chronic illness. Although these programs are thought to eventually pay for themselves in reduced use of hospitalization and emergency room care, improved health status is the main goal. Locally developed programs require intensive work on the part of several state staff, and many months of planning before implementation can begin.

Purchased DM programs

Florida received national attention for its efforts to purchase DM programs that would save state dollars for Medicaid. Over several years, Florida increased its number of contracts, which were each tailored to certain diseases. These projects were intended to save millions of dollars in utilization costs, and some, such as the contract for HIV/AIDS care, did achieve the desired savings within the first year. Achievement of program goals for other projects are more debatable, with the state arguing that utilization under the diabetes project actually increased expenditures. Regardless of whether the project achieved significant savings, state staff reported that there were many positive effects of these projects, including outreach to clients who were previously unknown to the system who were in dire need of health care.

The Center for Health Care Strategies reviewed the Florida experience after the first year, and reported these key findings:

- DM programs represent an option for managing care in the absence of fully capitated managed care through commercial health plans.
- DM can enhance Primary Care Case Management programs for states which have such efforts underway for managing care.
- DM programs offer an opportunity to improve the integration of care for Medicaid clients, especially those with special needs.
- Implementing DM may unveil structural issues in the care of Medicaid clients, including requirements for primary care providers' roles that may have been overlooked.
- A flexible procurement strategy can improve the state's ability to negotiate successful contracts for DM.
- States must hire or contract for sophisticated financial and administrative data analysis, which is critical to developing a DM program.
- A key challenge of program development is the creation of incentives to manage costs, which may be misaligned across the vendors and providers of care, and which may not be supported with adequate tools.
- Provider participation and support is critical.
- States may be more successful with a mandatory enrollment approach.

B. Literature Review: Economic Impact of Disease Management

There are numerous challenges in determining the economic impact of a disease management program. While many studies identify decreased cost with improved outcomes, the studies themselves are seldom designed as randomized, double blinded or peer reviewed. Further, data are often proprietary.[1] For example, one study of a diabetes case management program reported gross savings of $44 per member per month with a total cost decrease of 10.9%, yet did not include the costs of the program administration that was proprietary.[2]

In the article cited above by Rubin et al., several studies of diabetes case management programs are considered. The Diabetes Control and Complications Trial (DCCT) demonstrated a 50%-75% reduction in risk between standard and intensive treatment groups. The cost per member of the intensive treatment group was $4,000 to $5,800 annually. Investigators believe the long-term reduction in complications may defray, but not necessarily offset, the cost of intensive therapy. The article refers to a model developed by a physician with the National Institutes of Diabetes, Digestive and Kidney Diseases. His model assumes that intensive management of diabetes will prevent microvascular, but not macrovascular, complications of the disease. His model predicts a lifetime cost increase of $14,153 for a diabetic client. In contrast, the International Diabetes Center's Staged Diabetes Management program conducted a study of diabetics whose diabetes improved during a 6 to 12 month period. A pharmaceutical analysis predicted a net lifetime

[1] Bodenheimer, T. 2000. Disease management in the American market. *British Medical Journal* 320: 563-566.
[2] Rubin, R., Dietrich, K., Hawk, A. 1998. Clinical and economic impact of implementing a comprehensive diabetes management program in managed care. *Journal of Clinical Endocrinology and Metabolism* 83 (8): 2635-42.

savings of $27,000 per client, however the "break-even" point would not come for 6 to 7 years after enrollment in the program.

A randomized, controlled study conducted at a Kaiser Health Plan facility used a diabetes team to provide group education and management for poorly controlled diabetics. These services were coordinated with those of the primary care provider. The group's health status improved with similar costs for the intervention and control groups. Program expense was offset by a reduced rate of hospitalization in the intervention group.[3]

Consideration of an economic evaluation of a disease management program provided by a commercial vendor should include consideration of several factors. Commercial vendors, motivated by a profit factor, seek ways to provide services that yield short term cost reduction. High-risk clients are typically selected as they will have higher utilization rates that can be reduced. Low risk patients whose savings may be more long term are typically not the target of commercial vendors. Further, commercial vendors may not select strategies for improving health outcomes that are long term, such as lifestyle changes, as they will not yield cost containment in the short run.[4]

The results of the study of diabetics cited above that determined cost savings of $44 per member per month garnered comments from other researchers who felt there were flaws in the design.[5] Several of these include:

1. A decrease in inpatient costs and average length of stay mirrored a trend in the shift to outpatient care.
2. A need to include the costs of the program.
3. A non-diabetic comparison group was used so it was difficult to compare absolute dollar costs.

One additional consideration in evaluating the economic impact of a disease management program is whether or not one or all of the client's health problems are being considered. If a single disease such as asthma is being managed, it is necessary to consider excluding the cost of care for other health problems. This may give a better assessment of the cost impact of the disease management program. The caveat is that management of a single disease may improve health overall and reduce overall costs. A parallel analysis that evaluates single disease management cost effectiveness and changes in the overall change in the cost of care may be useful.

A study by Rossiter et al.[6] investigated the effectiveness of a disease management program for low-income people with asthma. The researchers identified people with asthma who had at least one claim for an asthma medication among the state of Virginia's Primary Care Case

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[3] Bodenheimer, T. 1999. Disease management – Promises and pitfalls. *New England Journal of Medicine* 340 (15): 1202-1205.
[4] Ibid.
[5] Gregg, E., Narayan, K., Engelau, M. 1999. Evaluating diabetes health services interventions: True effects, changing tides or moving targets? *Journal of Clinical Endocrinology and Metabolism* 84(3): 820.
[6] Rossiter, L. et al. 2000. The impact of disease management on outcomes and cost of care: A study of low-income asthma patients. *Inquiry* 37 (2): 188-201.

Management Medicaid program. This group was divided into intervention communities and comparison communities. These groups were identified for two fiscal years yielding two cohorts. A baseline household survey was used to verify the comparability of the intervention and comparison groups. The goal of this design was to see the total program impact on budget, rather than the impact of disease management on a panel of clients.

Cost evaluation began with analysis of the differences between the two groups for two quarters pre-intervention. A specific focus of the evaluation was whether or not there was an increase in the number of claims for guideline asthma drugs as well as a reduction in asthma emergency visits comparing one group to its comparison group for the same time period. Pre-intervention claims were compared to 5 quarters of post-intervention claims. The rate of reduction in emergency room use was 6% over the 5 quarters post-intervention for an estimated cost savings of $54,540. When the cost savings for emergency room use were figured based on the number of providers who participated and the cost of training for each one, the net cost savings were calculated to be $659 per provider. The estimated savings did not include the increased cost of the appropriate use of more medications nor did it include the cost of the design and research for provider training which was paid for by a grant. Other costs such as development of a communication skills curriculum were not included in the analysis and the researchers suggested this could spread over several disease management programs.

The Wealth from Health programs were developed in 1989 and implemented in 1991 by Betts Industries, Inc.[7] This disease and population management program includes modules for management of coronary artery disease, heart failure, asthma and diabetes. Patients for a study conducted in the late 1990s were selected from three different settings: an industrial site, employees of a hospital and patients in a clinic with chronic conditions. Medical costs are reported to have dropped dramatically over time primarily due to a drop in inpatient days, however, the cost analysis is incomplete and did not have verified comparison groups. Costs for one site were compared to claims data from comparable manufacturing companies. The hospital employee site had incomplete data. Data for the third site compared pre and post intervention data.

III. REQUEST FOR INFORMATION

Wanting to gain more information to build on the research described above, in August, MAA staff released a Request for Information (RFI) for entities interested in contracting for DM for the MAA population. We received over 40 responses, half from entities that were interested in contracting to develop local projects, and half from companies that provide DM services to states and private health plans across the country. Conditions identified for management included diabetes, renal disease, coronary artery disease, heart failure, asthma, etc.

From these responses, we received critical information about the possibilities that were available to MAA. Several companies were interested in serving clients with multiple conditions and comorbidities (disease states that tend to be associated with the primary disease), as opposed to

[7] Ratner, D. et al. 2001. Wealth from Health: An incentive program for disease management and population management. *In Lippincott's Case Management.*

single diseases. A few companies were focused on high-tech approaches, requiring active client participation and the ability to use computers and speak English. Local projects tended to have an active outreach program, an existing client base, and/or a provider community willing to work with the contractor. At least one project emphasized the unique nature of serving Medicaid clients with chronic illness, demonstrating an awareness of the challenges ahead. MAA used the list of respondents and several key elements of the responses in our preparation of the Request for Proposals. We also used the information to educate our panel of experts, which was convened in August with one meeting before and one after the RFI responses were received.

IV. WORK OF THE EXPERT PANEL

MAA faces challenges unique to service provision to the Medicaid population: first, we serve a clientele who speak multiple primary languages, may be less educated than the traditional commercial population, and may have first gained access to the state system through utilization of services for mental illness or drug and alcohol treatment. Second, whereas most DM programs are designed to fit into a system of managed care, Washington's DM project is intended to target clients in the FFS system who see multiple providers for their care. Finally, managed care companies and Department of Health efforts can take time to develop a program that achieves cost-savings, while MAA is expected to fund the DM program out of existing budgetary resources. Given these challenges to the contracting process, MAA decided to convene a panel of experts, supported by extensive data analysis conducted per their specifications, to inform our decisions as we developed the RFP. The panel included staff from DSHS administrations, Washington State Institute for Public Policy, Children's Hospital and Medical Center, and consultants from the fields of medicine, case management, and economics.

Data analysis

In December 2000, the Washington State Institute for Public Policy (WSIPP) reported to the Legislature its analysis of diseases that would be good candidates for case management. Based on cost of care and background research on which diseases can be managed to improve outcomes, WSIPP suggested a set of diseases and conditions, such as asthma, coagulation defects, malignancy, obesity, and diabetes. The report recommended further analysis of the disease groups to rule out other diseases to which high costs may actually be attributable.

This step was conducted for MAA by Milliman USA, using Calendar Year 2000 data on cost and utilization in FFS. Tables were prepared for the expert panel, showing a breakdown by eligibility category and analysis of claims history using the Chronic Disease Payment System (CDPS) risk grouping. The first analysis showed the extent of clients who fell into multiple groups by disease, which had high utilization, and which diagnoses were associated with high cost of care. Based on the low Medicaid costs of dual eligible Medicare-Medicaid clients, the panel determined that these clients would not be suitable for DM. If Medicare-related cost savings could be used to support Medicaid expenses for disease management, this population would be appropriate. This would require a change in federal policy.

The panel requested that the next level of analysis include a breakdown by services used through other DSHS divisions, and to look at the diagnoses associated with claims for diabetic clients. The second data analysis revealed that MAA's high-cost clients are shared by other DSHS divisions. While only one-third of all SSI/GAU clients use services from other divisions, more than two-thirds of the top 10% by medical expenses use services from other divisions. For example, 30% use mental health services, over 20% Aging and Adult Services, and 10% use services of more than one division.

A close examination of the 8,327 clients with a primary diagnosis of diabetes revealed that they tend to have multiple diagnoses. 5000 clients had diagnoses in each of the categories of neurological disorders, circulatory disorders, and respiratory disease, and over 2000 clients were diagnosed with mental illness. The panel concluded that high-risk case management that targets multiple diagnoses would be far more beneficial for these clients than a single disease approach. Selected data tables are included in the attachment to this report, and the complete set is available upon request.

Recommendations

The panel recommended that our RFP for disease management emphasize the following points:

1. Mental health needs must be addressed to decrease physical care costs;
2. Changing physician behavior is more difficult than it appears;
3. Case managers should serve as brokers to community services;
4. DM projects should coordinate and not supplant local resources;
5. DM projects should identify those clients at highest risk for case management.

V. REQUEST FOR PROPOSALS

In our Request for Proposal (RFP) released in October, MAA stated its intent to contract with organizations for Disease Management projects in one of the following categories: One contract for a statewide model, serving GAU and SSI eligible adult clients with multiple diseases and conditions, and two or more contracts for local projects serving a county or set of counties, or a health system catchment area. (The complete RFP may be found on our website: https://wws2.wa.gov/dshs/maa/HealthyOptions/PCCM.html.)

Although MAA anticipated awarding one contract for the statewide project, and one contract each for an adult and a children's project with a more local focus, we encouraged collaboration between bidders and considered awarding additional contracts if we receive proposals showing collaboration between two or more bidders.

Despite our efforts to support the multiple local projects that expressed interest through the RFI process (for example, preparing region-specific data sets with FFS claims and client eligibility), no local projects submitted proposals according to the specifications of the RFP. In fact, whereas over 40 projects were submitted for consideration in the RFI process, we only received four proposals to the RFP. Among the reasons for withdrawal, the following were mentioned:

- Inadequate time to demonstrate cost-savings in the remaining months of the biennium;

- Inadequate time to change utilization due to particular diseases under consideration;
- Unable to control costs of population due to voluntary nature of programs for children (based on rules established by Centers for Medicare and Medicaid);
- Inadequate financial support or commitment from MAA for start-up costs.

Additional funding for start-up and evaluation costs may have resulted in more creative projects, and may have allowed local projects to submit proposals. However, the four proposals that were submitted did allow the evaluators to choose among a variety of approaches. We are not contracting for three separate pilot projects, since the contractors combined management approaches for several diseases into one proposal.

Period of Performance: The anticipated start date of the contract resulting from this RFP is January 1, 2002. The beginning date for client enrollment will be no later than March 1, 2002. The contract end date is June 30, 2003. There is potential for up to a two-year extension, contingent on initial success.

The Contractor will be expected to take a holistic approach to managing certain disease state populations by attending to the complexities of multiple co-morbidities, including mental illness and lack of social support. MAA will not entertain single disease approaches for statewide or local adult projects. Disease management for a large segment of this population must rely heavily on care coordination and individual case management.

MAA will require that the Contractor provide the following services:

1. Deliver a comprehensive program that identifies patients at risk, targets them for interventions specific to their relative risk, provides infrastructure and systems that insure that these interventions occur, improves quality and cost outcomes for the client and DSHS, and coordinates with other health care providers.

2. Provide the following services to clients identified for enrollment in the Disease Management (DM) Project:

    - Provide assertive outreach to draw hard to serve clients into care.

    - Establish a medical home for clients who need a Primary Care Provider.

    - Assure that clients' medical care follows nationally recognized evidence based guidelines for practice whenever possible.
    - Identify clients at high risk for non-adherence to recommended care, and develop and implement individual care plans for high-risk clients.
    - Educate clients and/or their caregivers regarding the client's particular health care condition and needs brought about by their health problems.
    - Provide a 24 hour-a-day, seven day-a-week toll free nurse telephone consultation service to respond to clients' and/or caregivers' questions.

- Develop and circulate educational materials to communicate to clients about the disease management project and relevant health care information.
- Provide care coordination support and discharge planning for early hospital discharge, and to prevent readmissions.
- Provide initial assessment and periodic follow-up of the ongoing health status of the client.

The Contractor will be expected to provide the following information and support services to providers participating in the DM Project:

- Recruit providers to participate in the DM Project and serve as primary care providers for DM clients.
- Develop provider support for, and give provider education regarding, the specific evidence based guidelines selected for use.
- Implement a system for providers to request specific care coordination services.
- Give providers feedback on gaps between recommended prevention and treatment and actual care received by clients, and on client adherence to a plan of care.

Budget/cost proposals

The contractor is required to provide a guarantee of at least 5% savings in overall medical costs of the target population. MAA allowed cost proposals which include sharing of cost-savings beyond the 5% mandated by the legislature. MAA is receiving technical assistance to review the merits of cost-savings proposals through membership in the Disease Management Consortium.

The contractor was asked to include in their proposed budget adequate funds to reward MAA providers both for participation in the DM project and for serving as the identified client(s)' primary care provider. The contractors are also expected to bear one-half the cost of an external evaluation conducted by an outside evaluator.

VII. PROJECT EVALUATION

An Evaluation Committee was established with representatives of DSHS' Research and Data Analysis Division, Washington State Institute for Public Policy, the University of Washington, and MAA clinical and quality improvement staff. The committee developed the following evaluation methods for the Disease Management pilot:

1. For diseases and conditions in the enrolled population, the DM contractor will be asked to specify health process and outcome indicators that will be used to measure improvement in adherence to evidence-based guidelines for care. These health process and outcome indicators will be measured for the enrolled population at baseline and at 12 months or in accordance with the timeline recommended by the Evaluation Committee.

2. For the enrolled population, the DM contractor will measure utilization and medical costs. Measures should include number of hospital admits and readmits, number of emergency

room visits, and ambulatory visits. Utilization will be measured at baseline and monitored on a quarterly basis for trends.

3. The DM contractor will use a standardized tool to measure health status at baseline and at 12 months. Other measures of client health status and function, and knowledge of disease management processes will be reported to MAA and the University of Washington as collected.
4. Client satisfaction with the Disease Management project and staff will be measured by the DM contractor at 6 months of enrollment, or in accordance with the timeline recommended by the evaluator, and analyzed by MAA.
5. The contractor will document client experience, and measure access to, and satisfaction with health care at 6 and 18 months or in accordance with the timeline recommended by the evaluator.
6. The University of Washington will measure continuity of care at baseline, using FFS claims data, and after one year of client enrollment in the project, as an indicator of attainment of a medical home.
7. The University of Washington will measure admissions for ambulatory care sensitive conditions, or other avoidable hospitalizations, after one year of client enrollment in the project.
8. The University of Washington will analyze trends in medical utilization and costs based on 12 months experience.
9. MAA will survey or conduct focus sessions or interviews with providers and other state administrations and/or agencies, including relevant case managers, to assess satisfaction with the DM project.

The results of the evaluation will be available from MAA according to the timelines associated with the methods above. Intermittent measures such as client satisfaction, enrollment data, and access to care will be available in March 2003; final measures of cost savings and utilization changes will be available in January 2004. The timeline allows for complete submission of claims data, and the time required to match and analyze MAA data, data from other divisions, and data collected for the pilot project.

VIII. **NEXT STEPS**

The contractor will be expected to develop the necessary infrastructure to begin enrolling clients into Washington's Disease Management program by April 2002. Steps that will take place in the first two months include:

- obtaining the necessary data to identify clients who qualify for the program;
- establishing patterns of care and treating provider lists;
- working with the treating providers to gain their participation in the program;
- community meetings to introduce DM to local providers of care and service.

Client enrollment will be tracked closely over the first quarter. The contractor will be expected to conduct assessments as clients are enrolled, which may uncover needs for service or treatment. It is not unusual for costs to rise in the early months of a DM program, and these clients must be tracked in order to avoid negative impact on the Utilization and Cost Containment Initiative.

Evaluation efforts will be underway early in the program development, as MAA secures data-sharing agreements, assistance from the DSHS Human Subjects Review Board in protecting clients, and agreements with the University of Washington and other partners in evaluating the project. MAA staff are submitting a grant request for additional evaluation funding to support the development of a complex database and analysis of the collected data.

Table A-1
State of Washington Demographics
Categorically Needy, Medically Needy, and State Funded Members
Excluding Patients with Highest .6% of CDPS Coefficients

	Membership by Age/Gender				Percent			
Age Group	M	F	Unknown	Total	M	F	Unknown	Total
<5	7,919	7,367	0	15,286	6%	5%	0%	11%
5-14	19,670	17,048	1	36,719	14%	12%	0%	26%
15-19	5,641	6,196	0	11,837	4%	4%	0%	8%
20-39	13,084	17,573	6	30,663	9%	12%	0%	22%
40-59	14,588	20,372	8	34,968	10%	14%	0%	25%
60+	4,823	7,912	6	12,741	3%	6%	0%	9%
Total	65,725	76,468	21	142,214	46%	54%	0%	100%

Membership by Race	Members	Percent
Caucasian	80,219	56%
African American	7,764	5%
Asian American	8,233	6%
American Indian	13,319	9%
Hispanic	21,976	15%
Other	10,703	8%
Total	142,214	100%

Membership by Region (1)	Members	Percent
1	7,426	5%
2	13,369	9%
3a	31,322	22%
3b	15,811	11%
4	9,716	7%
5	11,466	8%
6	9,240	6%
7	8,019	6%
8	15,741	11%
9	2,391	2%
10	10,015	7%
11	1,415	1%
12	6,077	4%
40	206	0%
Total	142,214	100%

(1) Note that Region 3 has been divided into 3a (King County) and 3b (Pierce County).

Table A-2
State of Washington Summary
Categorically Needy, Medically Needy, and State Funded Members
Excluding Patients with Highest .6% of CDPS Coefficients

Membership

	Caucasian		African American		Asian American		American Indian		Hispanic		Other		Total		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
<5	3,336	2,981	238	215	243	193	1,142	1,170	2,000	1,901	960	907	7,919	7,367	15,286
5-14	7,916	6,261	838	657	774	636	2,453	2,450	5,830	5,361	1,859	1,683	19,670	17,048	36,718
15-19	2,817	2,939	279	284	279	271	544	858	1,225	1,331	497	513	5,641	6,196	11,837
20-39	9,596	12,088	910	1,099	397	531	680	2,016	796	1,163	705	676	13,084	17,573	30,657
40-59	10,469	14,823	1,351	1,414	716	1,352	670	1,044	698	855	684	884	14,588	20,372	34,960
60+	2,596	4,383	216	261	1,065	1,774	126	166	315	500	505	828	4,823	7,912	12,735
Total	36,730	43,475	3,832	3,930	3,474	4,757	5,615	7,704	10,864	11,111	5,210	5,491	65,725	76,468	142,193
							Inpatient Costs								
<5	$1,912,128	$1,597,594	$327,908	$128,865	$430,315	$225,314	$416,270	$421,397	$1,226,471	$1,502,769	$517,132	$876,735	$4,830,224	$4,752,674	$9,582,898
5-14	$2,625,735	$1,897,137	$326,887	$321,381	$86,665	$86,259	$276,381	$404,405	$823,300	$1,290,701	$354,544	$293,081	$4,493,512	$4,292,965	$8,786,477
15-19	$2,100,013	$1,910,752	$528,873	$251,097	$200,327	$55,614	$260,106	$991,723	$400,439	$632,012	$218,694	$201,553	$3,708,452	$4,042,752	$7,751,204
20-39	$10,104,833	$12,609,159	$1,593,962	$1,491,250	$666,543	$535,171	$1,177,879	$3,041,167	$1,646,001	$1,265,098	$1,132,391	$674,088	$16,321,609	$19,615,933	$35,937,542
40-59	$17,759,535	$21,653,751	$2,467,695	$2,365,795	$1,044,701	$700,685	$1,688,865	$1,588,811	$1,216,543	$1,306,133	$875,662	$1,170,508	$25,053,000	$28,785,682	$53,838,682
60+	$4,101,203	$5,599,705	$271,518	$402,275	$802,687	$1,087,393	$402,387	$264,286	$438,354	$744,273	$675,809	$573,179	$6,691,956	$8,671,111	$15,363,067
Total	$38,603,448	$45,268,098	$5,516,843	$4,960,662	$3,231,238	$2,690,436	$4,221,886	$6,711,790	$5,751,107	$6,740,987	$3,774,232	$3,789,144	$61,098,754	$70,161,116	$131,259,870
							Inpatient Admissions								
<5	245	206	26	18	25	7	81	67	122	96	78	53	577	447	1,024
5-14	328	261	40	38	12	10	46	53	103	128	38	37	567	527	1,094
15-19	185	411	60	56	9	15	27	252	39	284	17	67	337	1,085	1,422
20-39	1,424	2,770	210	307	58	119	118	833	118	307	99	157	2,027	4,493	6,520
40-59	2,383	3,389	341	358	72	133	196	245	139	190	116	134	3,247	4,449	7,696
60+	483	771	44	53	99	163	57	46	71	88	63	90	817	1,211	2,028
Total	5,048	7,808	721	830	275	447	525	1,496	592	1,093	411	538	7,572	12,212	19,784
							Inpatient Costs per Member								
<5	$573	$536	$1,378	$599	$1,771	$1,167	$365	$360	$613	$791	$539	$967	$610	$645	$627
5-14	$332	$303	$390	$489	$112	$136	$113	$165	$141	$241	$191	$174	$228	$252	$239
15-19	$745	$650	$1,896	$884	$718	$205	$478	$1,156	$327	$475	$440	$393	$657	$652	$655
20-39	$1,053	$1,043	$1,752	$1,357	$1,679	$1,008	$1,732	$1,509	$2,068	$1,088	$1,606	$997	$1,247	$1,116	$1,172
40-59	$1,696	$1,461	$1,827	$1,673	$1,459	$518	$2,521	$1,522	$1,743	$1,528	$1,280	$1,324	$1,717	$1,413	$1,540
60+	$1,580	$1,278	$1,257	$1,541	$754	$613	$3,194	$1,592	$1,392	$1,489	$1,338	$692	$1,388	$1,096	$1,206
Total	$1,051	$1,041	$1,440	$1,262	$930	$566	$752	$871	$529	$607	$724	$690	$930	$918	$923
							Inpatient Admissions per 1,000 Members								
<5	73	69	109	84	103	36	71	57	61	50	81	58	73	61	67
5-14	41	42	48	58	16	16	19	22	18	24	20	22	29	31	30
15-19	66	140	215	197	32	55	50	294	32	213	34	131	60	175	120
20-39	148	229	231	279	146	224	174	413	148	264	140	232	155	256	213
40-59	228	229	252	253	101	98	293	235	199	222	170	152	223	218	220
60+	186	176	204	203	93	92	452	277	225	176	125	109	169	153	159
Total	137	180	188	211	79	94	93	194	54	98	79	98	115	160	139
							Emergency Room Costs								
<5	$60,655	$41,732	$3,286	$4,945	$2,040	$513	$40,640	$20,962	$34,846	$29,998	$14,936	$12,936	$156,405	$111,087	$267,492
5-14	$97,557	$77,507	$11,709	$10,786	$3,101	$5,207	$28,661	$42,338	$70,018	$50,083	$13,614	$10,318	$224,660	$196,238	$420,898
15-19	$60,749	$84,813	$20,726	$8,305	$1,557	$1,104	$10,185	$41,212	$14,632	$25,889	$7,218	$8,533	$115,067	$169,857	$284,924
20-39	$689,750	$1,121,526	$114,809	$125,826	$19,051	$25,565	$60,779	$157,852	$38,146	$61,995	$28,317	$66,184	$950,852	$1,558,948	$2,509,800
40-59	$958,708	$1,312,101	$209,706	$196,163	$23,086	$37,976	$111,910	$107,233	$63,027	$61,939	$41,433	$54,569	$1,407,870	$1,769,981	$3,177,850
60+	$157,470	$234,454	$15,989	$20,456	$24,488	$47,877	$11,065	$9,956	$18,713	$20,570	$16,340	$17,102	$244,066	$350,416	$594,482
Total	$2,024,890	$2,872,133	$376,225	$366,482	$73,323	$118,243	$263,240	$379,553	$239,383	$250,473	$121,859	$169,642	$3,098,919	$4,156,526	$7,255,445

Table A-2
State of Washington Summary
Categorically Needy, Medically Needy, and State Funded Members
Excluding Patients with Highest .6% of CDPS Coefficients

Emergency Room Visits

	Caucasian		African American		Asian American		American Indian		Hispanic		Other		Total		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
<5	396	315	15	23	14	7	277	204	262	234	92	85	1,056	868	1,924
5-14	598	488	66	55	15	19	261	261	371	347	82	80	1,393	1,250	2,643
15-19	381	539	76	31	8	7	64	182	75	142	24	45	628	946	1,574
20-39	3,698	5,702	350	497	61	90	262	915	187	356	132	197	4,690	7,757	12,447
40-59	3,750	5,965	570	644	71	127	392	444	178	251	150	217	5,111	7,648	12,759
60+	396	747	44	42	58	107	49	39	85	71	47	57	679	1,063	1,742
Total	9,219	13,756	1,121	1,292	227	357	1,305	2,045	1,158	1,401	527	681	13,557	19,532	33,089
Emergency Room Visits per 1,000 Members															
<5	119	106	63	107	58	36	243	174	131	123	96	94	133	118	126
5-14	76	78	79	84	19	30	106	107	64	65	44	48	71	73	72
15-19	135	183	272	109	29	26	118	212	61	107	48	88	111	153	133
20-39	385	472	385	452	154	169	385	454	235	306	187	291	358	441	406
40-59	358	402	422	455	99	94	585	425	255	294	219	245	350	375	365
60+	153	170	204	161	54	60	389	235	270	142	93	69	141	134	137
Total	251	316	293	329	65	75	232	265	107	126	101	124	206	255	233
Other Costs (Including Prescription Drugs)															
<5	$5,083,761	$4,086,175	$484,005	$456,355	$466,866	$185,643	$1,258,482	$1,286,862	$2,156,333	$1,456,641	$1,151,036	$860,679	$10,600,483	$8,332,354	$18,932,837
5-14	$15,870,858	$9,481,557	$1,087,381	$691,147	$749,315	$417,570	$2,492,177	$2,441,322	$3,780,513	$3,088,639	$1,483,265	$1,575,713	$25,463,509	$17,695,948	$43,159,457
15-19	$6,270,995	$5,109,899	$509,986	$374,629	$327,364	$421,747	$670,606	$1,456,066	$702,103	$1,334,219	$424,036	$438,363	$8,905,089	$9,134,922	$18,040,011
20-39	$28,276,090	$38,578,529	$2,181,178	$3,034,264	$1,395,694	$1,496,677	$1,520,536	$5,407,086	$2,154,193	$2,505,346	$2,074,916	$1,826,217	$37,602,608	$52,848,118	$90,450,725
40-59	$43,257,532	$80,209,397	$5,527,756	$6,488,661	$2,468,346	$4,332,986	$2,655,061	$4,681,949	$2,670,524	$3,600,246	$2,850,052	$3,567,908	$59,429,271	$102,881,147	$162,310,418
60+	$12,128,875	$22,849,698	$1,067,560	$1,282,932	$3,648,428	$5,792,941	$512,840	$807,085	$957,218	$1,966,777	$1,477,487	$2,691,091	$19,792,409	$35,390,523	$55,182,932
Total	$110,888,111	$160,315,254	$10,857,866	$12,327,987	$9,056,013	$12,647,564	$9,109,703	$16,080,368	$12,420,884	$13,951,867	$9,460,791	$10,959,971	$161,793,369	$226,283,011	$388,076,380
Other Costs (Including Prescription Drugs) per Member															
<5	$1,524	$1,371	$2,034	$2,123	$1,921	$962	$1,102	$1,100	$1,078	$766	$1,199	$949	$1,339	$1,131	$1,239
5-14	$2,005	$1,514	$1,298	$1,052	$968	$657	$1,016	$996	$648	$576	$798	$936	$1,295	$1,038	$1,175
15-19	$2,226	$1,739	$1,828	$1,319	$1,173	$1,556	$1,233	$1,697	$573	$1,002	$853	$855	$1,579	$1,474	$1,524
20-39	$2,947	$3,191	$2,397	$2,761	$3,516	$2,819	$2,236	$2,682	$2,706	$2,154	$2,943	$2,702	$2,874	$3,007	$2,950
40-59	$4,132	$5,411	$4,092	$4,589	$3,447	$3,205	$3,963	$4,485	$3,826	$4,211	$4,167	$4,036	$4,074	$5,050	$4,643
60+	$4,672	$5,213	$4,942	$4,915	$3,426	$3,265	$4,070	$4,862	$3,039	$3,934	$2,926	$3,250	$4,104	$4,473	$4,333
Total	$3,019	$3,688	$2,833	$3,137	$2,607	$2,659	$1,622	$2,087	$1,143	$1,256	$1,816	$1,996	$2,462	$2,959	$2,729
Total Costs															
<5	$7,056,545	$5,725,502	$815,200	$590,165	$899,221	$411,470	$1,715,392	$1,729,221	$3,417,650	$2,989,407	$1,683,104	$1,750,350	$15,587,112	$13,196,114	$28,783,226
5-14	$18,594,151	$11,456,201	$1,425,977	$1,023,314	$839,082	$509,037	$2,797,218	$2,888,065	$4,673,831	$4,429,422	$1,851,423	$1,879,112	$30,181,681	$22,185,151	$52,366,831
15-19	$8,431,758	$7,105,464	$1,059,585	$634,031	$529,248	$478,466	$940,896	$2,489,001	$1,117,174	$1,992,120	$649,947	$648,449	$12,728,609	$13,347,531	$26,076,140
20-39	$39,070,673	$52,309,213	$3,889,949	$4,651,340	$2,081,288	$2,057,413	$2,759,194	$8,606,105	$3,838,340	$3,832,439	$3,235,625	$2,566,488	$54,875,069	$74,022,998	$128,898,067
40-59	$61,975,775	$103,175,249	$8,205,156	$9,050,619	$3,536,133	$5,071,647	$4,455,836	$6,377,993	$3,950,093	$4,968,317	$3,767,147	$4,792,985	$85,890,140	$133,436,810	$219,326,950
60+	$16,387,547	$28,683,856	$1,355,067	$1,705,662	$4,475,603	$6,928,211	$926,292	$1,081,327	$1,414,285	$2,731,621	$2,169,636	$3,281,372	$26,728,431	$44,412,049	$71,140,480
Total	$151,516,448	$208,455,485	$16,750,934	$17,655,131	$12,360,575	$15,456,243	$13,594,829	$23,171,711	$18,411,373	$20,943,327	$13,356,882	$14,918,756	$225,991,041	$300,600,654	$526,591,695
Total Costs per Member															
<5	$2,115	$1,921	$3,425	$2,745	$3,700	$2,132	$1,502	$1,478	$1,709	$1,573	$1,753	$1,930	$1,968	$1,791	$1,883
5-14	$2,349	$1,830	$1,702	$1,558	$1,084	$800	$1,140	$1,179	$802	$826	$996	$1,117	$1,534	$1,301	$1,426
15-19	$2,993	$2,418	$3,798	$2,233	$1,897	$1,766	$1,730	$2,901	$912	$1,497	$1,308	$1,264	$2,256	$2,154	$2,203
20-39	$4,072	$4,327	$4,275	$4,232	$5,243	$3,875	$4,058	$4,269	$4,822	$3,295	$4,590	$3,797	$4,194	$4,212	$4,205
40-59	$5,920	$6,960	$6,073	$6,401	$4,939	$3,751	$6,651	$6,109	$5,659	$5,811	$5,508	$5,422	$5,888	$6,550	$6,274
60+	$6,313	$6,544	$6,273	$6,535	$4,202	$3,905	$7,352	$6,514	$4,490	$5,463	$4,296	$3,963	$5,542	$5,613	$5,586
Total	$4,125	$4,795	$4,371	$4,492	$3,558	$3,249	$2,421	$3,008	$1,695	$1,885	$2,564	$2,717	$3,438	$3,931	$3,703

Table B-1
Diagnosis Groupings Based on All ICD9 Codes*
Detail Data Summary for Categorically Needy, Medically Needy and State Funded Members
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	ICD 9 codes	Patients	Total Paid
A01	Infections, General	006 - 009 , 038 - 041 , 053 - 054 , 077 - 079 , 110 - 139 , 321 - 324 , 390	8,623	$86,652,402
A02	Infections With Public Health Implications (excluding HIV/AIDS)	001 - 005 , 010 - 018 , 020 - 036 , 045 - 052 , 055 - 069 , 071 - 072 , 080 - 104 , 320 , 487	2,447	15,219,985
A03	HIV / AIDS and related diseases (Kaposi's)	042 , 176	577	9,129,808
B01	Respiratory malignancies	140 - 149 , 160 - 162 , 231	274	6,011,775
B02	GI malignancies	150 - 159 , 230	237	4,383,455
B03	Breast Cancer	174	424	6,270,724
B04	Leukemia	203 - 208	176	3,233,492
B05	Other malignancies	163 - 173 , 175 , 177 - 202	1,208	21,961,129
B06	Neoplasm of uncertain behavior	235 - 239	1,224	16,585,066
C01	Endocrine disorders except diabetes	240 - 249 , 251 - 255 , 257 - 259	4,017	38,412,444
C02	Diabetes	250	7,866	76,461,964
C03	Nutritional Deficiencies	260 - 269	570	11,547,524
C04	Other Metabolic Disorders, includes cystic fibrosis	270 - 271 , 273 - 277	3,238	54,988,117
D01	Immune disorders, Disorders of white blood cells	279 , 288	413	10,369,855
D02	Hereditary anemia (sickle cell, thalessemia)	282	123	1,930,540
D03	Bleeding disorders - Coagulation defects, and hemorrhagic conditions	286 - 287	559	10,955,601
D04	Other hematologic disorders Anemia and other hematopoetic disorders	280 - 281 , 283 - 285	3,220	49,114,299
E01	Non organic psychosis - Schizophrenic disorders, affective psychosis, delusional disorders	295 - 299	8,811	80,321,987
E02	Organic psychosis and dementias (except alcohol)	290 , 293 , 310	514	10,020,248
E03	Depression & adjustment reaction	309 , 311	4,509	43,388,693
E04	Eating disorders	278 , 307.5, 783	3,528	50,697,580
E05	Childhood mental health issues - Disorders of childhood, includes ADD	313 - 315	2,838	20,595,171
E06	Other mental health disorders	300 - 302 , 312 , 316 , 797 , 306 - 307.4 , 307.8 - 308	6,195	59,053,806
E07	Mental retardation	317 - 319	296	4,052,768
E08	Alcoholic psychosisDrug psychosisAlcohol other substance abuse	291 - 292 , 303 - 305	7,134	77,612,588
F01	Childhood neurologic problems - Infantile CP, and congenital neurological disorders	343 , 740 - 743	2,018	29,305,247

Table B-1
Diagnosis Groupings Based on All ICD9 Codes*
Detail Data Summary for Categorically Needy, Medically Needy and State Funded Members
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	ICD 9 codes	Patients	Total Paid
F02	Epilepsy	345	2,327	$27,479,838
F03	Headaches	346	1,645	16,653,178
F04	Other CNS diseases except epilepsy, headaches, and congenital and infantile CP	325 - 344, 347 - 349	3,134	60,724,508
F05	Diseases of the peripheral nervous system and sense organs except eyes	350 - 359 , 380 - 389	11,196	80,704,914
F06	Disorders of the eyes	360 - 379	22,204	138,221,162
G01	Diseases of the pulmonary circulation	416 - 417	184	5,573,564
G02	Congenital CV anomalies of the heart, lungs, and great vessels	745 - 748	753	16,929,105
G03	Lipid disorders - Disorders of lipid metabolism	272	5,117	41,425,711
G04	Hypertension	401 - 405	10,401	89,582,126
G05	Ischemic Heart Disease	410 - 414	2,692	41,122,539
G06	Peripheral vascular disease - Diseases of arteries (PVD, aneurysm, etc)	440 - 448	935	18,546,951
G07	Cerebrovascular disease	430 - 438	1,561	30,942,920
G08	CHF - Acute cor pulmonale,Congestive Heart Failure	404.11, 404.91, 415 , 425 , 428 , 398.91, 401.11, 402.01, 402.91, 404.01	1,913	35,149,132
G09	Other heart disease (Rheumatic Fever, Rheumatic Heart Disease, myocarditis, valvular disease, conductive disorders)	390 - 398 , 420 - 424 , 426 - 427 , 429	3,362	53,015,997
H01	Diseases of the upper respiratory tract	460 - 478 , 784	26,101	165,753,974
H02	COPD, other obstructive pulmonary disease except asthma	490 - 492 , 494 - 496	4,752	58,503,688
H03	Asthma	493	5,464	52,594,543
H04	Other pulmonary disease - Pneumonia and Influenza and other non specified pulmonary conditions	480 - 487 , 500 - 519 , 786	15,505	199,421,129
I01	UGI disorders - Diseases of esophagus, stomach, and duodenum	530 - 537	5,771	69,468,353
I02	Inflammatory bowel disease - Noninfectious enteritis and colitis	555 - 558	2,225	21,087,943
I03	Hepatitis and liver diseases	070 , 570 - 573	3,349	38,818,456
I04	Other GI disorders	520 - 529 , 538 - 569, 574 - 579 , 751 , 787	14,193	157,632,505
J01	Nephritis, Nephrotic Syndrome and Nephrosis (includes chronic renal failure)	580 - 589	643	13,622,785
J02	Other upper GU disorders including congenital	590 - 599 , 753 , 788 , 791	11,895	121,292,891

Table B-1
Diagnosis Groupings Based on All ICD9 Codes*
Detail Data Summary for Categorically Needy, Medically Needy and State Funded Members
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	ICD 9 codes	Patients	Total Paid
J03	Male genital tract disease including congenital and excluding malignancies	600 - 608 , 752.5 - 752.6	1,400	$11,429,273
K01	GYN diseases - Uterine Fibroids, benign neoplasm of ovary, other benign female genital neoplasm	218 - 221	381	3,764,101
K02	Non malignant disorders of the breast	610 - 611	1,694	14,219,184
K03	Ovarian dysfunction	256	86	665,514
K04	Other Female genital disorders including congenital	612 - 629 , 752.1 - 752.4	8,656	61,834,610
K05	Complications of Pregnancy	630 - 677	3,208	24,763,937
K06	Congenital anomalies	749 - 750 , 752 , 754 - 756 , 758 - 759	1,719	20,507,088
K07	Perinatal problems - Certain conditions originating in the perinatal period (includes fetal alcohol syndrome and others)	760 - 779	1,020	20,143,574
L01	Skin diseases - Diseases Of Skin And Subcutaneous Tissue, Including Congenital Anomalies	680 - 709 , 757 , 782	14,392	133,242,318
M01	Connective tissue disorders,Polymyalgia	710 , 725	473	5,219,436
M02	Peripheral arthritic conditions - RA, OA, crystal arthropathies, etc	711 - 716	5,153	46,893,646
M03	Diseases of the spine - Dorsopathies (neck, back, disc disease, etc.)	720 - 724	11,796	101,968,125
N01	Fractures	800 - 829	4,238	48,354,930
N02	Sprains and Strains	840 - 848	9,117	65,897,289
N03	Superficial injuries, contusions, abrasions	910 - 924	6,514	48,972,033
N04	Poisoning by medicinal and biological substances	960 - 979	1,142	16,492,831
N05	Poisoning by non-medicinal substances	980 - 989	543	5,368,923
O01	All other	All Other	90,077	492,745,850
			-	

*Note that if an individual had multiple diagnoses across groups, their total dollars were counted toward each group.

Table B-2
Diagnosis Groupings Based on All ICD9 Codes*
Percentile Summary for Categorically Needy, Medically Needy and State Funded Members
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	ICD 9 codes	Patients	Total Annual Claims		
				50th Percentile	75th Percentile	90th Percentile
A01	Infections, General	006 - 009 , 038 - 041 , 053 - 054 , 077 - 079 , 110 - 139 , 321 - 324 , 390	8,623	$3,597	$10,128	$23,562
A02	Infections With Public Health Implications (excluding HIV/AIDS)	001 - 005 , 010 - 018 , 020 - 036 , 045 - 052 , 055 - 069 , 071 - 072 , 080 - 104 , 320 , 487	2,447	2,040	6,088	15,881
A03	HIV / AIDS and related diseases (Kaposi's)	042 , 176	577	11,874	19,745	31,239
B01	Respiratory malignancies	140 - 149 , 160 - 162 , 231	274	12,993	30,577	54,156
B02	GI malignancies	150 - 159 , 230	237	10,820	25,623	47,368
B03	Breast Cancer	174	424	8,298	20,383	33,721
B04	Leukemia	203 - 208	176	7,506	24,903	50,634
B05	Other malignancies	163 - 173 , 175 , 177 - 202	1,208	9,459	23,671	45,753
B06	Neoplasm of uncertain behavior	235 - 239	1,224	7,332	16,119	31,823
C01	Endocrine disorders except diabetes	240 - 249 , 251 - 255 , 257 - 259	4,017	5,054	11,139	22,405
C02	Diabetes	250	7,866	5,785	11,213	21,472
C03	Nutritional Deficiencies	260 - 269	570	9,016	24,091	52,762
C04	Other Metabolic Disorders, includes cystic fibrosis	270 - 271 , 273 - 277	3,238	9,004	20,025	42,791
D01	Immune disorders, Disorders of white blood cells	279 , 288	413	11,517	27,080	59,839
D02	Hereditary anemia (sickle cell, thalessemia)	282	123	8,741	19,399	40,134
D03	Bleeding disorders - Coagulation defects, and hemorrhagic conditions	286 - 287	559	9,608	23,896	47,924
D04	Other hematologic disorders Anemia and other hematopoetic disorders	280 - 281 , 283 - 285	3,220	6,392	16,889	40,988
E01	Non organic psychosis - Schizophrenic disorders, affective psychosis, delusional disorders	295 - 299	8,811	5,843	10,800	19,399
E02	Organic psychosis and dementias (except alcohol)	290 , 293 , 310	514	9,414	25,763	49,950
E03	Depression & adjustment reaction	309 , 311	4,509	5,192	11,063	22,125
E04	Eating disorders	278 , 307.5, 783	3,528	5,885	14,385	34,643
E05	Childhood mental health issues - Disorders of childhood. includes ADD	313 - 315	2,838	2,668	6,290	14,816
E06	Other mental health disorders	300 - 302 , 312 , 316 , 797 , 306 - 307.4 , 307.8 - 308	6,195	5,471	11,542	21,857
E07	Mental retardation	317 - 319	296	6,953	13,942	29,253
E08	Alcoholic psychosisDrug psychosisAlcohol other substance abuse	291 - 292 , 303 - 305	7,134	5,885	12,838	25,092
F01	Childhood neurologic problems - Infantile CP, and congenital neurological disorders	343 , 740 - 743	2,018	6,327	13,762	30,331
F02	Epilepsy	345	2,327	$6,138	$12,689	$25,587
F03	Headaches	346	1,645	6,335	12,427	22,001
F04	Other CNS diseases except epilepsy, headaches, and congenital and infantile CP	325 - 344, 347 - 349	3,134	9,170	22,584	49,867
F05	Diseases of the peripheral nervous system and sense organs except eyes	350 - 359 , 380 - 389	11,196	2,848	7,474	16,298
F06	Disorders of the eyes	360 - 379	22,204	2,687	6,756	14,174

Table B-2
Diagnosis Groupings Based on All ICD9 Codes*
Percentile Summary for Categorically Needy, Medically Needy and State Funded Members
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	ICD 9 codes	Patients	Total Annual Claims		
				50th Percentile	75th Percentile	90th Percentile
G01	Diseases of the pulmonary circulation	416 - 417	184	19,286	38,135	66,374
G02	Congenital CV anomalies of the heart, lungs, and great vessels	745 - 748	753	6,458	24,365	59,783
G03	Lipid disorders - Disorders of lipid metabolism	272	5,117	4,770	9,390	18,008
G04	Hypertension	401 - 405	10,401	4,382	9,441	19,431
G05	Ischemic Heart Disease	410 - 414	2,692	9,598	19,267	34,281
G06	Peripheral vascular disease - Diseases of arteries (PVD, aneurysm, etc)	440 - 448	935	10,763	24,366	45,415
G07	Cerebrovascular disease	430 - 438	1,561	10,071	24,223	50,945
G08	CHF - Acute cor pulmonale,Congestive Heart Failure	404.11, 404.91, 415 , 425 , 428 , 398.91, 401.11, 402.01, 402.91, 404.01	1,913	11,060	22,397	44,774
G09	Other heart disease (Rheumatic Fever, Rheumatic Heart Disease, myocarditis, valvular disease, conductive disorders)	390 - 398 , 420 - 424 , 426 - 427 , 429	3,362	7,851	18,218	39,138
H01	Diseases of the upper respiratory tract	460 - 478 , 784	26,101	2,545	6,882	14,555
H02	COPD, other obstructive pulmonary disease except asthma	490 - 492 , 494 - 496	4,752	6,537	14,240	29,100
H03	Asthma	493	5,464	5,056	10,790	21,993
H04	Other pulmonary disease - Pneumonia and Influenza and other non specified pulmonary conditions	480 - 487 , 500 - 519 , 786	15,505	5,919	13,608	29,775
I01	UGI disorders - Diseases of esophagus, stomach, and duodenum	530 - 537	5,771	6,195	13,163	27,747
I02	Inflammatory bowel disease - Noninfectious enteritis and colitis	555 - 558	2,225	4,337	10,958	23,406
I03	Hepatitis and liver diseases	070 , 570 - 573	3,349	6,461	13,516	25,824
I04	Other GI disorders	520 - 529 , 538 - 569, 574 - 579 , 751 , 787	14,193	5,617	12,277	24,945
J01	Nephritis, Nephrotic Syndrome and Nephrosis (includes chronic renal failure)	580 - 589	643	10,305	25,371	54,485
J02	Other upper GU disorders including congenital	590 - 599 , 753 , 788 , 791	11,895	4,953	11,021	23,263
J03	Male genital tract disease including congenital and excluding malignancies	600 - 608 , 752.5 - 752.6	1,400	$4,156	$8,599	$16,994
K01	GYN diseases - Uterine Fibroids, benign neoplasm of ovary, other benign female genital neoplasm	218 - 221	381	7,566	12,321	19,115
K02	Non malignant disorders of the breast	610 - 611	1,694	5,254	10,415	18,235
K03	Ovarian dysfunction	256	86	4,664	11,289	20,008
K04	Other Female genital disorders including congenital	612 - 629 , 752.1 - 752.4	8,656	4,149	8,655	15,556
K05	Complications of Pregnancy	630 - 677	3,208	4,920	8,374	14,609
K06	Congenital anomalies	749 - 750 , 752 , 754 - 756 , 758 - 759	1,719	4,287	10,919	26,350
K07	Perinatal problems - Certain conditions originating in the perinatal period (includes fetal alcohol syndrome and others)	760 - 779	1,020	8,298	16,940	40,501

Table B-2
Diagnosis Groupings Based on All ICD9 Codes*
Percentile Summary for Categorically Needy, Medically Needy and State Funded Members
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	ICD 9 codes	Patients	Total Annual Claims		
				50th Percentile	75th Percentile	90th Percentile
L01	Skin diseases - Diseases Of Skin And Subcutaneous Tissue, Including Congenital Anomalies	680 - 709 , 757 , 782	14,392	4,272	10,116	21,849
M01	Connective tissue disorders,Polymyalgia	710 , 725	473	6,668	13,899	25,964
M02	Peripheral arthritic conditions - RA, OA, crystal arthropathies, etc.	711 - 716	5,153	5,321	11,130	21,137
M03	Diseases of the spine - Dorsopathies (neck, back, disc disease, etc.)	720 - 724	11,796	4,896	10,164	19,229
N01	Fractures	800 - 829	4,238	4,348	11,466	27,203
N02	Sprains and Strains	840 - 848	9,117	3,841	8,735	16,773
N03	Superficial injuries, contusions, abrasions	910 - 924	6,514	3,327	8,352	18,042
N04	Poisoning by medicinal and biological substances	960 - 979	1,142	8,850	18,413	31,192
N05	Poisoning by non-medicinal substances	980 - 989	543	4,922	11,328	22,818
O01	All other	All Other	90,077	1,916	5,595	12,521

*Note that if an individual had multiple diagnoses across groups, their total dollars were counted toward each group.

Table C-1
Patients with Services Provided by the Aging and Adult Services Administration (AASA)
Data Summary for Categorically Needy, Medically Needy and State Funded Members
Diagnosis Groupings Based on Primary ICD9 Codes
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	Patients	Total Paid	Paid per Patient	Prescriptions	Rx Paid	Admits	IP Paid	ER Visits	ER Paid
A	Infectious Diseases	1,776	$2,433,483	$1,370	11,922	$900,658	73	$514,712	51	$6,556
B	Malignancies	613	2,606,318	4,252	6,431	431,221	50	621,940	3	2,339
C	Endocrine and metabolic Disorders	2,570	5,229,948	2,035	38,247	1,759,696	144	859,853	84	36,462
D	Hematologic disorders	728	1,004,768	1,380	4,784	234,932	33	180,884	29	10,423
E	Mental Health and substance abuse	2,577	6,536,300	2,536	35,444	2,068,765	257	1,485,300	288	60,840
F	Neurologic and sensory disorders	4,697	10,306,143	2,194	43,137	2,318,550	98	632,104	240	50,684
G	Circulatory and vascular disease	3,824	11,436,016	2,991	49,714	1,969,649	420	4,523,420	103	67,809
H	Respiratory disease	4,593	11,715,330	2,551	58,786	2,730,102	486	3,847,331	693	242,372
I	GI and digestive disorders	2,952	7,024,352	2,380	21,496	1,102,347	329	2,614,651	255	59,123
J	GU disease	2,648	4,844,081	1,829	27,367	1,255,369	110	596,076	130	38,238
K	Women's issues	1,613	1,507,401	935	8,824	412,574	71	363,082	38	9,212
L	Skin Diseases	2,798	4,398,379	1,572	21,414	1,049,289	140	957,913	148	30,020
M	Orthopedic and Rhuematologic disorders	2,681	4,300,792	1,604	27,049	1,431,879	136	1,196,991	201	29,323
N	Injuries and accidents	2,110	4,845,232	2,296	12,983	583,267	177	2,693,063	505	110,149
O	All Other	7,882	37,712,137	4,785	207,593	9,778,036	642	6,364,336	1,203	331,129
	Total Members (1)	8,114								

(1) This is not a sum of the Patients column. Patients may be counted multiple times based on primary diagnosis codes. This is the total number of individual members.

Table C-2
Patients with Services Provided by the Division of Alcohol and Substance Abuse (DASA)
Data Summary for Categorically Needy, Medically Needy and State Funded Members
Diagnosis Groupings Based on Primary ICD9 Codes
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	Patients	Total Paid	Paid per Patient	Prescriptions	Rx Paid	Admits	IP Paid	ER Visits	ER Paid
A	Infectious Diseases	1,706	$1,112,369	$652	6,029	$465,435	55	$275,596	132	$20,587
B	Malignancies	297	691,142	2,327	1,615	91,228	25	207,451	2	1,269
C	Endocrine and metabolic Disorders	1,030	1,093,207	1,061	9,264	395,089	69	283,632	77	25,228
D	Hematologic disorders	343	297,575	868	1,089	63,503	21	134,049	14	6,732
E	Mental Health and substance abuse	5,287	13,456,066	2,545	65,373	3,688,618	820	3,256,305	824	178,821
F	Neurologic and sensory disorders	3,218	1,621,046	504	10,636	501,035	32	157,109	400	93,712
G	Circulatory and vascular disease	1,697	2,511,633	1,480	15,172	520,166	119	1,294,703	61	32,937
H	Respiratory disease	4,660	5,091,112	1,093	33,039	1,289,264	264	1,809,509	932	228,600
I	GI and digestive disorders	3,137	4,276,794	1,363	17,862	992,885	307	1,720,362	525	96,246
J	GU disease	1,246	894,859	718	4,804	211,121	41	175,284	127	33,471
K	Women's issues	1,868	2,135,391	1,143	6,626	248,284	298	848,339	158	41,466
L	Skin Diseases	2,301	2,226,748	968	10,997	469,059	175	888,609	358	62,889
M	Orthopedic and Rhuematologic disorders	2,485	2,512,293	1,011	20,143	910,852	77	487,713	326	41,610
N	Injuries and accidents	3,095	3,629,134	1,173	13,322	511,548	221	1,511,282	1,196	289,205
O	All Other	8,174	13,677,769	1,673	90,823	4,463,836	519	2,845,693	1,601	403,074
	Total Members (1)	8,736								

(1) This is not a sum of the Patients column. Patients may be counted multiple times based on primary diagnosis codes. This is the total number of individual members.

Table C-3
Patients with Services Provided by the Division of Developmental Disabilities (DDD)
Data Summary for Categorically Needy, Medically Needy and State Funded Members
Diagnosis Groupings Based on Primary ICD9 Codes
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	Patients	Total Paid	Paid per Patient	Prescriptions	Rx Paid	Admits	IP Paid	ER Visits	ER Paid
A	Infectious Diseases	1,959	$856,375	$437	5,235	$262,962	34	$211,916	62	$9,632
B	Malignancies	180	357,072	1,984	860	48,833	7	67,178	-	0
C	Endocrine and metabolic Disorders	1,079	1,452,231	1,346	7,743	477,608	65	308,134	22	10,516
D	Hematologic disorders	326	431,972	1,325	971	51,020	9	34,173	2	1,816
E	Mental Health and substance abuse	4,110	7,269,600	1,769	31,465	2,013,521	182	1,191,310	232	41,731
F	Neurologic and sensory disorders	6,183	14,361,459	2,323	37,220	2,012,747	102	606,257	151	28,605
G	Circulatory and vascular disease	1,048	2,293,021	2,188	5,405	241,867	46	695,801	10	3,778
H	Respiratory disease	4,510	7,278,710	1,614	19,606	889,713	298	2,309,129	359	66,379
I	GI and digestive disorders	2,599	4,580,734	1,762	8,384	469,719	178	1,294,763	200	33,901
J	GU disease	2,406	3,535,118	1,469	15,809	800,497	53	357,864	54	10,945
K	Women's issues	2,168	5,205,431	2,401	7,615	321,122	104	591,746	58	10,913
L	Skin Diseases	2,333	1,178,025	505	7,917	360,312	26	154,266	93	10,267
M	Orthopedic and Rhuematologic disorders	575	312,358	543	2,179	93,972	9	47,085	32	3,183
N	Injuries and accidents	1,657	1,255,196	758	4,090	209,285	32	384,749	354	54,041
O	All Other	10,435	22,975,141	2,202	99,066	5,136,278	324	2,436,646	783	166,226
	Total Members (1)	11,645								

(1) This is not a sum of the Patients column. Patients may be counted multiple times based on primary diagnosis codes. This is the total number of individual members.

Table C-4
Patients with Services Provided by the Mental Health Division (MHD)
Data Summary for Categorically Needy, Medically Needy and State Funded Members
Diagnosis Groupings Based on Primary ICD9 Codes
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	Patients	Total Paid	Paid per Patient	Prescriptions	Rx Paid	Admits	IP Paid	ER Visits	ER Paid
A	Infectious Diseases	4,440	$2,755,661	$621	20,682	$1,431,902	92	$497,842	252	$34,267
B	Malignancies	846	1,776,502	2,100	5,458	331,823	41	431,687	2	372
C	Endocrine and metabolic Disorders	3,984	5,601,158	1,406	50,321	2,770,204	192	811,994	156	66,880
D	Hematologic disorders	988	838,738	849	5,243	284,222	27	158,498	12	4,015
E	Mental Health and substance abuse	13,335	35,354,084	2,651	201,078	14,182,215	2,503	12,936,845	1,958	388,985
F	Neurologic and sensory disorders	9,973	9,358,215	938	56,454	3,215,347	118	645,793	788	147,100
G	Circulatory and vascular disease	5,018	8,288,481	1,652	48,656	2,350,612	288	3,059,974	133	69,923
H	Respiratory disease	12,119	15,631,960	1,290	109,937	5,427,064	563	3,481,763	2,124	525,291
I	GI and digestive disorders	7,369	10,545,424	1,431	49,270	2,962,717	547	3,426,641	1,002	182,681
J	GU disease	4,174	3,969,073	951	27,524	1,463,887	97	474,251	303	74,569
K	Women's issues	5,293	5,109,982	965	25,991	1,229,906	454	1,475,603	309	76,107
L	Skin Diseases	6,226	4,697,265	754	35,287	1,874,928	190	925,707	511	75,594
M	Orthopedic and Rhuematologic disorders	5,754	6,036,444	1,049	52,680	2,598,063	146	1,062,313	561	69,608
N	Injuries and accidents	6,882	7,240,664	1,052	33,459	1,526,105	392	2,787,900	2,151	440,927
O	All Other	22,384	47,025,188	2,101	358,037	20,486,248	876	6,406,481	3,275	761,176
	Total Members (1)	23,565								

(1) This is not a sum of the Patients column. Patients may be counted multiple times based on primary diagnosis codes. This is the total number of individual members.

Table C-5
Patients with services provided by more than one organization (1)
Data Summary for Categorically Needy, Medically Needy and State Funded Members
Diagnosis Groupings Based on Primary ICD9 Codes
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	Patients	Total Paid	Paid per Patient	Prescriptions	Rx Paid	Admits	IP Paid	ER Visits	ER Paid
A	Infectious Diseases	838	$1,046,295	$1,249	5,776	$446,897	34	$210,089	37	$4,688
B	Malignancies	199	783,128	3,935	2,164	130,671	15	179,146	2	1,212
C	Endocrine and metabolic Disorders	967	2,221,792	2,298	14,558	719,916	59	305,752	44	19,666
D	Hematologic disorders	305	374,550	1,228	2,002	95,475	6	25,402	3	541
E	Mental Health and substance abuse	1,699	5,153,030	3,033	28,000	1,724,253	239	1,379,183	257	52,603
F	Neurologic and sensory disorders	1,921	5,153,483	2,683	19,176	1,095,477	46	229,341	152	35,501
G	Circulatory and vascular disease	1,239	3,940,024	3,180	15,403	697,749	115	1,367,704	41	23,382
H	Respiratory disease	1,888	5,989,066	3,172	24,309	1,181,076	226	1,947,195	351	107,939
I	GI and digestive disorders	1,319	3,520,306	2,669	10,796	607,110	170	1,248,250	147	29,965
J	GU disease	1,129	1,928,292	1,708	11,981	624,545	38	204,335	69	20,357
K	Women's issues	771	758,255	983	4,193	201,251	33	147,578	25	4,949
L	Skin Diseases	1,255	2,264,480	1,804	9,764	507,645	88	604,390	94	17,257
M	Orthopedic and Rhuematologic disorders	1,007	1,666,104	1,655	10,672	554,209	58	444,646	107	13,925
N	Injuries and accidents	1,036	2,467,561	2,382	6,475	328,196	100	1,335,424	313	75,570
O	All Other	3,240	17,637,702	5,444	90,417	4,785,865	310	2,906,970	710	189,669
	Total Members (2)	3,306								

(1) AASA, DASA, DDD or MHD.
(2) This is not a sum of the Patients column. Patients may be counted multiple times based on primary diagnosis codes. This is the total number of individual members.

Table C-6
Patients with no services provided AASA, DASA, DDD or MHD
Data Summary for Categorically Needy, Medically Needy and State Funded Members
Diagnosis Groupings Based on Primary ICD9 Codes
Excluding Patients with Highest .6% of CDPS Coefficients

	Diagnosis Group	Patients	Total Paid	Paid per Patient	Prescriptions	Rx Paid	Admits	IP Paid	ER Visits	ER Paid
A	Infectious Diseases	11,700	$4,763,503	$407	26,917	$1,561,903	209	$1,385,002	431	$53,734
B	Malignancies	2,360	9,682,676	4,103	15,999	1,078,035	277	3,753,479	19	8,406
C	Endocrine and metabolic Disorders	7,806	8,234,371	1,055	96,236	4,334,904	296	1,466,063	178	62,449
D	Hematologic disorders	2,521	2,774,496	1,101	9,636	631,933	186	1,085,610	46	23,994
E	Mental Health and substance abuse	9,585	7,838,274	818	57,500	2,656,087	402	1,669,643	358	78,290
F	Neurologic and sensory disorders	27,408	12,856,116	469	84,002	3,742,456	152	1,252,661	988	134,019
G	Circulatory and vascular disease	12,523	21,551,412	1,721	116,596	4,603,173	1,089	10,845,161	253	176,968
H	Respiratory disease	33,211	23,156,743	697	182,996	6,803,818	1,131	6,057,529	2,788	670,656
I	GI and digestive disorders	15,024	15,743,205	1,048	63,622	2,985,416	1,000	5,976,644	1,159	253,423
J	GU disease	7,880	6,962,516	884	32,786	1,310,720	206	917,716	364	86,307
K	Women's issues	10,465	11,603,562	1,109	31,511	1,212,750	1,350	5,479,714	389	104,985
L	Skin Diseases	13,288	4,998,950	376	47,232	1,835,106	202	930,552	646	82,513
M	Orthopedic and Rhuematologic disorders	11,517	11,281,028	980	92,905	4,017,064	344	2,635,118	577	69,950
N	Injuries and accidents	11,974	10,351,758	865	35,538	1,260,770	389	5,036,106	2,247	388,139
O	All Other	71,392	67,994,511	952	490,287	19,686,171	2,180	14,603,912	3,711	839,112
	Total Members (1)	100,167								

(1) This is not a sum of the Patients column. Patients may be counted multiple times based on primary diagnosis codes. This is the total number of individual members.

Table C-7
Summary by Region
Excluding Patients with Highest .6% of CDPS Coefficients

Data Summary for Categorically Needy, Medically Needy and State Funded Members

Region		AASA (1)	DASA (2)	DDD (3)	MHD (4)	Multiple (5)	None (6)
1		342	615	590	1,391	140	5,063
2		605	724	885	1,736	208	10,121
3a	(7)	2,265	2,331	2,552	5,708	906	21,003
3b	(8)	1,160	945	1,795	3,421	487	9,878
4		396	659	779	1,611	202	6,922
5		641	627	845	1,912	295	8,229
6		624	547	731	1,973	207	6,118
7		289	348	480	933	107	6,351
8		350	743	815	1,329	156	13,112
9		150	154	146	345	55	1,733
10		980	730	1,246	2,148	418	5,918
11		47	33	91	192	22	1,106
12		251	266	661	824	94	4,487
40	(9)	14	14	29	42	9	126
Total		8,114	8,736	11,645	23,565	3,306	100,167

(1) Patients with any services provided by the Aging and Adult Services Administration.
(2) Patients with any services provided by the Division of Alcohol and Substance Abuse.
(3) Patients with anyservices provided by the Division of Developmental Disabilities.
(4) Patients with any services provided by the Mental Health Division.
(5) Patients with services provided by more that one of the previously listed organizations ((1) - (4)).
Note that all of these patients are also counted with organizations who provided the services.
(6) Patients with no services provided by any of the above listed orgaziations ((1) - (4)).
(7) King County.
(8) Pierce County.
(9) Region unknown.

Table C-8
Summary by Region
Most Expensive Patients (Total Paid Amount in Highest 10%)

Data Summary for Categorically Needy, Medically Needy and State Funded Members

Region		AASA (1)	DASA (2)	DDD (3)	MHD (4)	Multiple (5)	None (6)
1		156	137	52	288	71	275
2		264	137	131	363	98	438
3a	(7)	1,081	559	407	1,443	534	1,284
3b	(8)	524	213	311	839	248	645
4		171	81	89	264	81	296
5		288	110	106	353	126	499
6		230	118	104	417	112	313
7		132	55	70	161	57	297
8		187	98	113	240	90	412
9		57	24	20	75	21	107
10		355	128	197	515	195	469
11		31	7	22	43	16	51
12		103	55	80	164	48	207
40	(9)	9	3	6	10	8	12
Total		3,588	1,725	1,708	5,175	1,705	5,305

(1) Patients with any services provided by the Aging and Adult Services Administration.
(2) Patients with any services provided by the Division of Alcohol and Substance Abuse.
(3) Patients with anyservices provided by the Division of Developmental Disabilities.
(4) Patients with any services provided by the Mental Health Division.
(5) Patients with services provided by more that one of the previously listed organizations ((1) - (4)).
Note that all of these patients are also counted with organizations who provided the services.
(6) Patients with no services provided by any of the above listed orgaziations ((1) - (4)).
(7) King County.
(8) Pierce County.
(9) Region unknown.